AIA PUBLIC TAKAFUL

ATTENDING PHYSICIAN'S STATEMENT

Critical Illness – AIDS Due to Blood Transfusion / Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection

To be completed by Registered Medical Practitioner at Person Covered's / Claimant's own expense

Certificate No:	IC No:	Age:
Name of Person Covered:		Gender: ☐ Male ☐ Female

Part I - General Information

1. (a) Are you the Person Covered's usual medical physician?	1. (a) ☐ Yes ☐ No
(b) If "Yes", over what period do your records extend?	(b) _____
2. (a) When were you first consulted for this illness?	2. (a) _____ (MM/DD/YYYY)
(b) What were the symptoms/complaints?	(b) _____
(c) How long had the symptoms/complaints existed :-	
(i) According to the patient?	(c) (i) _____ Day/s _____ Week/s _____ Month/s _____ Year/s
(ii) In your medical opinion?	(ii) _____ Day/s _____ Week/s _____ Month/s _____ Year/s
3. (a) Has the Person Covered previously suffered from this illness or any related illnesses?	3. (a) ☐ Yes ☐ No
(b) If "Yes", please give dates of consultations and the resulting diagnosis.	(b) _____
(c) Was the patient referred to you?	(c) ☐ Yes ☐ No
(i) If Yes, when?	(i) _____ (MM/DD/YYYY)
(ii) Reasons for referral?	(ii) _____
(iii) Name and address of the referral doctors.	(iii) _____
4. (a) On what date was the diagnosis made?	4. (a) _____ (MM/DD/YYYY)
(b) On what date was the Person Covered first made aware of it?	(b) _____ (MM/DD/YYYY)
5. Please state if there is anything in the Person Covered's family history which would have increased the risk of this illness.	5. _____

6. Which of the following factors are present?

		Date of Onset (MM/DD/YYYY)
a) Past history of controlled hypertension	Yes / No	_____
b) Past history of uncontrolled hypertension	Yes / No	_____
c) Diabetes Mellitus	Yes / No	_____
d) Obesity	Yes / No	_____
e) Chronic smoker	Yes / No	_____
f) Heavy drinker	Yes / No	_____
g) Stress	Yes / No	_____
h) Hyperlipidaemia	Yes / No	_____

i) Others, please specify : _____

Part II - Details of the Person Covered's Illness

1. Please provide full and exact details of the diagnosis.	1. _____
2. Please describe the cause of infection. A. AIDS due to Blood Transfusion	2. A.
a. (i) Was the infection due to blood transfusion?	a (i) ☐ Yes ☐ No
(ii) Was the blood transfusion medically necessary or given as part of medical treatment?	(ii) ☐ Yes ☐ No
(iii) Was the blood transfusion received in Malaysia or Singapore?	(iii) ☐ Yes ☐ No
(iv) Was the infection resulted from any other means including sexual activity and the use of intravenous drugs?	(iv) ☐ Yes ☐ No
b. (i) Is the source of infection established from the institution that provided the blood transfusion?	b (i) ☐ Yes ☐ No
(ii) Is the institution able to trace the origin of the HIV tainted blood?	(ii) ☐ Yes ☐ No
c. Is the patient suffering from Thalassaemia Major or Haemophilia?	c. ☐ Yes ☐ No
d. Was an HIV antibody test done before the blood transfusion? If "Yes", what was the result?	d. ☐ Yes ☐ No _____
B. Occupationally Acquired HIV Infection a. Is the Person Covered a medical staff working in Malaysia? If "Yes", please check the appropriate item.	B. a. ☐ General Physician ☐ Specialist ☐ Nurse ☐ Laboratory Technician ☐ Dentist ☐ Ambulance Worker of medical centre, hospital or dental clinic/polyclinic
b. Please state the Person Covered's normal occupational duties.	b. _____
c. Is the HIV infection acquired as a result of an accident occurring during the course of carrying out normal occupational duties?	c. ☐ Yes ☐ No
d. For Accident case, please state below: (i) Date of Accident (ii) Place of Accident (iii) How did the Accident happen?	d. (i) _____ (MM/DD/YYYY) (ii) _____ (iii) _____
e. (i) Was there a HIV test carried out? (ii) Date of HIV test taken	e. (i) ☐ Yes ☐ No (ii) _____ (MM/DD/YYYY)
f. Was the HIV infection as a result of sexual activity, blood transfusions or recreational intravenous drug use?	f. ☐ Yes ☐ No
3. Was the Person Covered treated by any other doctors or hospitals? If "Yes", please provide us the dates, names and addresses of the doctors / hospitals.	3. _____
4. Has the Person Covered suffered from/been treated for any other illnesses or complaints other than this Critical Illness? If "Yes", please give full details.	4. _____
5. If there is any further information which in your opinion will assist us in assessing this claim, please furnish such information.	5. _____

Note: For AIDS due to blood transfusion or Occupationally Acquired Human Immunodeficiency Virus (HIV) Infection claim, please enclose copies of all blood test done, HIV profile test, chest X-ray, laboratory test study, etc and any relevant reports that are available.

I hereby certify that I have personally examined and treated the Person Covered for his / her injuries / illnesses described above and that the facts as stated above represent my medical opinion of his / her condition.

_____ Qualification: _____
Signature of Attending Physician

Name & Address: _____ Date: _____
(Official Stamp) (MM/DD/YYYY)

_____

Contact No.: _____